# 8. Heavy Care Residents

Under Adult Care Home Personal Care (ACH/PC) coverage, all residents who are eligible for Special Assistance and Medicaid qualify for a fixed daily payment (Basic ACH/PC) to the adult care home for providing personal care assistance. Basic ACH/PC is paid at two rates based on the size of the facility (number of licensed beds in the facility). There is one rate for facilities with less than thirty-one total licensed beds and a separate rate for facilities with thirty-one or more total licensed beds, see Appendix I. Medication administration is included in the applicable Basic ACH/PC payment. Residents who meet the Medicaid criteria for being "heavy care" residents also qualify for higher "Enhanced" ACH/PC payments to cover the costs of their extra care needs, and are eligible for case management services as well. This section outlines the Medicaid "heavy care" criteria and procedures for an Adult Care Home Case Management Services (ACH/CMS) case manager to verify the resident's eligibility and authorize Enhanced ACH/PC payments.

## 8.1 What is a Heavy Care Resident

Eating and toileting, as well as bathing, dressing, ambulation/locomotion, and transferring, are basic functional skills known as "activities of daily living" (ADLs). A heavy care resident is an individual residing in an adult care home who according to the Medicaid criteria for evaluating a resident's dependency on others for assistance with ADLs needs "extensive assistance" or is "totally dependent" on another person for:

- eating;
- toileting;
- eating and toileting;
- ambulation/locomotion.

See Appendix H of this manual for a detailed explanation of what is included in eating, toileting, and ambulation/locomotion, the Medicaid criteria for evaluating a resident's dependency on others for assistance with ADLs, and the codes for rating ADL needs.

If you use the DMA-3050 to assess and document a resident's abilities, limitations, and personal care needs, and you entered a performance code of "3" (extensive assistance) or "4" (totally dependent) for either eating, toileting, and/or ambulation/locomotion in item #17, he or she is a potential heavy care resident. If you use your own authorization and care plan form to assess residents' personal care needs, you can also identify a potential heavy care resident by rating the individual's degree of dependence on others for assistance with eating, toileting, eating and toileting, and ambulation/locomotion by the same criteria in Appendix H.

## 8.2 What is Enhanced ACH/PC

Under ACH/PC coverage, an individual who meets the Medicaid criteria for being a heavy care resident is eligible for Enhanced ACH/PC payments, higher rates paid to the adult care home provider to cover the costs of the heavy care resident's extra care needs. Enhanced ACH/PC is paid at four daily rates based upon the type of assistance needed by the heavy care resident with eating, toileting, eating and toileting and ambulation/locomotion. These payment rates and codes for billing them are in Appendix I.

A heavy care resident's eligibility for Enhanced ACH/PC payments does not limit the type or amount of personal care assistance you provide for the resident or diminish your responsibilities as conditions for accepting Medicaid payments. The personal care assistance performed for a heavy

care resident includes assistance with eating, toileting, and/or ambulation/locomotion and any other ADL or personal care tasks that are listed in the resident's ACH/PC Care Plan.

Questions about ACH/PC covered tasks and Enhanced ACH/PC payments should be addressed to the Provider Services Unit at Electronic Data Systems (EDS). The address and telephone number for the EDS' Provider Services Unit is in Appendix B.

## 8.3 What is ACH/CMS

A resident who meets the Medicaid coverage criteria for being a heavy care resident is also eligible for Adult Care Home Case Management Services (ACH/CMS). The purpose of ACH/CMS is to provide a case manager to work in partnership with the heavy care resident, and resident's family, significant others, the adult care home, and service providers to assure that the resident's personal care and other health care service needs are being met. ACH/CMS covers the costs of the ACH/CMS provider having a qualified case manager perform the following case management activities:

- verifying that a resident meets the Medicaid criteria for being a heavy care resident;
- reviewing the heavy care resident's ACH/PC care plan to assure that the resident's personal care needs are adequately addressed;
- authorizing Enhanced ACH/PC payments to the adult care home;
- monitoring the heavy care resident's condition and determining if the tasks in the adult care home's care plan are being performed in a manner appropriate to the needs of the resident;
- providing consultation and assistance to the adult care home when needed for assessment and care planning;
- assessing and reassessing the broader health care service needs of the heavy care resident;
- preparing an Adult Care Home Case Management Service Plan to address the overall health care service needs of the heavy care resident with Medicaid-covered services, whenever possible;
- working with the adult care home, the heavy care resident, and the resident's family or responsible party to locate and arrange for other health and social services which support the provision of Medicaid-funded services;
- coordinating services when multiple service providers are involved in the heavy care resident's care; and
- determining that services received are appropriate and adequate for meeting the heavy care resident's needs and that the services are consistent with accepted standards for quality of care.

## 8.4 Getting Coverage for a Heavy Care Resident

The identification of a heavy care resident must be independently verified by an ACH/CMS case manager according to the Medicaid criteria for evaluating a resident's dependency on others for assistance with ADLs in Appendix H. Ordinarily, the home would identify a potential heavy care resident during an assessment or reassessment and make the referral to the ACH/CMS provider. However, the referral may also come from a variety of sources, i.e., a physician, nurse, family member, responsible party, adult home specialist, or others. In any case, you must cooperate with the

ACH/CMS case manager evaluating a resident's eligibility for coverage by providing records of assessment findings and other supporting documentation to verify that the individual meets the Medicaid criteria and is eligible for these services. You may not deny a resident access to Medicaid-covered services for which the resident qualifies.

The steps for the ACH/CMS case manager to verify a potential heavy care resident's eligibility and authorize Enhanced ACH/PC and ACH/CMS coverage are outlined below.

### Step 1 Contact ACH/CMS Provider to Request an Evaluation

When you identify a potential heavy care resident, contact the appropriate ACH/CMS provider and request that the ACH/CMS case manager conduct an evaluation to verify that this resident meets the Medicaid coverage criteria.

In most instances, the county department of social services is the appropriate ACH/CMS provider and responsible for verifying eligibility, authorizing Enhanced ACH/PC and ACH/CMS coverage, and providing ACH/CMS for the heavy care resident. The area mental health program is the appropriate ACH/CMS provider if the potential heavy care resident has been or is currently a CAP-MR/DD client or "Thomas S" client; or has been or is currently receiving treatment, case management, or other services through the area mental health program or its agents. The area mental health program may be the appropriate ACH/CMS provider if the potential heavy care resident has been or is currently residing in a DDA group home; has a past history of mental illness or psychiatric hospitalization; or may be mentally ill and in need of treatment and/or other services through the area mental health program. The county DSS and area mental health program will determine the appropriate provider of ACH/CMS activities in uncertain situations.

Record in the resident's records the name of the staff person who made the referral, the name of the case manager at the DSS or area mental health program who was contacted, and the date of the referral.

### Step 2 Give Referral Documents to ACH/CMS Provider

Give the following "referral documents" to the ACH/CMS provider:

- a copy of the DMA-3050 (or your own authorization and care plan) signed and dated by the administrator or person designated by the administrator to assess residents' needs; and

- copies of any other available documentation supporting your assessment findings, such as copies of the resident's FL2 or notes made by staff who provide care.

These referral documents will be maintained in the ACH/CMS provider's records and will not be returned to you.

*Note: The resident's DMA-3050 (or your own authorization and care plan form) need not be signed by the resident's physician before it is forwarded to the ACH/CMS provider for review or before Enhanced ACH/PC and ACH/CMS coverage may be authorized.*

### Step 3 The Case Manager's Evaluation

A case manager employed by or acting under arrangement for the ACH/CMS provider will:

- establish that the resident is eligible for Special Assistance (SA) and Medicaid and not a "disenfranchised" resident;

- review the assessment findings and any supporting documentation supplied by the home as referral documents;

- obtain copies of any other relevant documents from other sources, such as nursing notes or hospital records;

- conduct an independent assessment of the resident's need for assistance with eating, toileting, and/or ambulation/locomotion by personal observation as well as asking the home's staff, the resident's family or responsible party, or others who are knowledgeable about the resident's needs;

- observe the resident going about his or her usual daily routine in order to assess abilities and limitations, although it is not necessary for the case manager to directly observe the resident toileting; and

- evaluate whether the resident meets the Medicaid coverage criteria for being a heavy care resident.

At times, the case manager may not immediately be able to verify that a referred resident meets the coverage criteria. If this is the case, you should together take the following steps to come to a mutually agreeable conclusion about the resident's eligibility for Enhanced ACH/PC and ACH/CMS coverage:

- Review the supporting documentation and any additional documentation with the case manager. Be sure you gave the case manager copies of all the documents you used to assess the resident's needs and identify the individual as a heavy care resident. Try to get any other relevant documents to further clarify the resident's abilities, limitations, and need for assistance, including nursing notes from any recent hospital admissions, mental health treatment notes, or other physical or psychological evaluations.

- Reassess the resident's abilities, limitations, and need for assistance with eating, toileting and/or ambulation/locomotion. Also, talk with the staff who care for the resident, the resident's physician, or family members who are knowledgeable about the resident's current abilities and limitations. A resident's functioning may improve or decline during the course of a day or because of a change in daily activities. It may be helpful to conduct another assessment together at a different time of day or on a different day of the week than earlier assessments.

- Resolve any discrepancies. Attempt to resolve any discrepancies in the documentation or statements of caregivers or others which conflict with the assessment of the resident's abilities, limitations, and need for assistance.

  *Example: An administrator and a case manager are reviewing Elmo Craddock's eligibility for Enhanced ACH/PC and ACH/CMS coverage. Mr. Craddock's most recent hospital discharge summary states that he needed no assistance for ambulation or toileting at the time of his discharge. This statement is not consistent with the home's assessment or the case manager's observations. The hospital nursing notes mention his need for staff assistance to transfer and use a bedside commode during the admission. After consulting with Mr. Craddock's physician, the case manager noted in Mr. Craddock's case file that the hospital discharge summary appears to be incorrect and other documentation confirms that he meets the coverage criteria. The case manager authorized Enhanced ACH/PC payments for the extra assistance he needs with toileting.*

If the resident dies or is discharged after the referral is made, the case manager will complete the evaluation and, if possible, make a decision based on available information regarding the resident's eligibility for Enhanced ACH/PC during the time period prior to the date of death or discharge.

### Step 4 The Case Manager's Decision

Within 30 calendar days from the date of receiving the referral documents, the case manager must complete the evaluation of the resident's eligibility for coverage and decide whether to authorize Enhanced ACH/PC and ACH/CMS coverage. You may bill for the Basic ACH/PC rate while the case manager's decision is pending and adjust the claims once an Enhanced ACH/PC rate is authorized (see Section 10).

- **Meets Medicaid Coverage Criteria**

  If the case manager agrees that the resident meets the Medicaid coverage criteria for being a heavy care resident, the case manager must document the decision and contact EDS' Prior Approval Unit. The case manager will authorize the Enhanced ACH/PC rate to be paid to you for dates of service on and after the effective date for coverage. EDS' Prior Approval Unit staff will enter this information in the claims processing data base and give the case manager a PA "confirmation number" for making inquiries about that authorization in the future.

  The case manager will send the resident and you a "Decision Notice" authorizing you to receive a specific level of Enhanced ACH/PC payments for dates of service on and after the effective date for the coverage. The effective date should be the date the current authorization and care plan form (DMA-3050 or the home's own form) was completed and signed by the administrator or staff person assigned to conduct assessments, but may not be more than 90 days prior to the date of the Decision Notice. The effective date is the first date of service you may bill at the authorized Enhanced ACH/PC rate and starts the annual cycle for the authorization of Enhanced ACH/PC. The Decision Notice will also include an end date 365 days after the effective date when the authorization of Enhanced ACH/PC payments will end, unless the resident's eligibility ends or another decision is made about coverage before that time.

  After receiving your copy of the case manager's Decision Notice, you may bill the authorized Enhanced ACH/PC rate for dates of service on and after the effective date established by the case manager. Note that receiving the ACH/CMS case manager's authorization and/or a confirmation number does not guarantee payment. Other requirements for Medicaid reimbursement must also be met.

- **Does Not Meet Coverage Criteria**

  If the case manager does not agree that the referred resident meets the coverage criteria for being a heavy care resident, the case manager will notify the resident and you of the decision to deny Enhanced ACH/PC and ACH/CMS coverage. The case manager must send a Decision Notice to the resident and a copy to you to explain the decision, the effective date for the denial, and your right to request a hearing to review the decision. For guidance on appealing case managers' decisions, see Section 9.

## 8.5 When a Heavy Care Resident's Needs Change

When a heavy care resident experiences a significant change (as defined in the Glossary in Appendix A) in condition, you must refer the resident to the resident's physician or other appropriate licensed health professional, conduct a reassessment, and, if appropriate, revise the ACH/PC care plan, according to the procedures and timeframes in Section 5.2 of this manual. In addition, you must report any significant change or improvement in the heavy care resident's condition to the ACH/CMS case manager within 10 calendar days from the date the change occurred. Provide the case manager with a copy of your reassessment findings. Document in the resident's records the name of the person(s) who contacted the case manager, the date(s) of the contact(s), and the name of the case manager who was contacted.

Within 30 calendar days of being notified about a significant change or improvement in the heavy care resident's condition, the ACH/CMS case manager must re-evaluate the resident's needs, determine if he continues to meet the Medicaid criteria for being a heavy care resident, and verify his continuing eligibility for Enhanced ACH/PC payments and ACH/CMS. The case manager must decide whether the resident:

- continues to meet the coverage criteria and qualifies for the same Enhanced ACH/PC payment rate;
- continues to meet the coverage criteria and qualifies for a different Enhanced ACH/PC payment rate; or
- no longer meets the coverage criteria and Enhanced ACH/PC and ACH/CMS must be discontinued.

The case manager must send a Decision Notice to the resident and a copy to you to explain the decision to continue, change, or discontinue Enhanced ACH/PC and ACH/CMS coverage, the effective date for the decision, and your right to request a hearing to review the decision. The case manager must also determine whether the change in the resident's condition warrants any revisions in the resident's case management service plan and make the appropriate changes.

## 8.6 When a Heavy Care Resident Dies or is Discharged

Medicaid does not cover ACH/PC payments (Basic, Enhanced, or therapeutic leave) or ACH/CMS for dates of service after a resident has died or is discharged from the adult care home.

### 8.6.1 Notifying the Case Manager

You must notify the heavy care resident's ACH/CMS case manager immediately, orally or in writing, if the heavy care resident has:

- deceased;
- been discharged from the adult care home and is living in a private home; or
- been discharged from the adult care home and admitted to another adult care home, a hospital, a nursing facility, or an intermediate care facility for the mentally retarded (ICF-MR).

### 8.6.2 Re-admitting a Heavy Care Resident and Resuming Coverage

How you handle a re-admission after a discharge depends on where the heavy care resident resided during the absence: in a private home, adult care home, hospital, nursing facility, or ICF-MR. Follow the procedures in Section 7.3 of this manual for re-admitting a heavy care resident after a discharge.

Enhanced ACH/PC payments and ACH/CMS are not resumed automatically when a heavy care resident is re-admitted. You must contact the resident's ACH/CMS case manager. Based on the length of the absence and the circumstances of the re-admission, the case manager will re-evaluate the resident's eligibility for Enhanced ACH/PC and ACH/CMS coverage or continue the current authorization as follows:

- **Re-evaluating Eligibility for Enhanced ACH/PC Payments**

  In the following situations the case manager is required to re-evaluate the re-admitted resident's continuing eligibility; make a decision to continue, change, or discontinue Enhanced ACH/PC and ACH/CMS coverage; and send a Decision Notice to the resident and the home:

  - the home conducted a new assessment and completed a new ACH/PC care plan; or
  - 30 calendar days or more have passed since the resident was discharged from the home to a hospital, nursing facility, or ICF-MR; or
  - either the case manager or the home believes a re-evaluation of the resident's eligibility for coverage is appropriate as a result of a change in the need for assistance.

  If the case manager re-authorizes Enhanced ACH/PC payments, the effective date for this authorization starts a new annual schedule for the case manager to re-evaluate the resident's eligibility and re-authorize Enhanced ACH/PC payments within 12 months.

- **Continuing the Current Authorization of Enhanced ACH/PC Payments**

  If you re-admitted the heavy care resident within 30 calendar days of discharge and you resumed ACH/PC using the resident's existing care plan, the case manager may continue the currently authorized Enhanced ACH/PC payments without re-evaluating the resident's eligibility for Enhanced ACH/PC and ACH/CMS coverage. In this situation, the case manager will continue the current authorization of Enhanced ACH/PC payments and is not required to send the resident or you a Decision Notice. This will continue the current annual schedule for the case manager to re-evaluate and re-authorize Enhanced ACH/PC payments 12 months after the effective date in the most recent Decision Notice.

## 8.7 Annual Assessments for Heavy Care Residents

Before ACH/PC payments (Basic, Enhanced, or Therapeutic leave) may continue for more than one calendar year, you must re-assess the heavy care resident's continuing need for ACH/PC, prepare a new care plan, and have the service re-authorized by a physician according to the policies and procedures in Section 5.3 of this manual. In addition, Enhanced ACH/PC payments for a heavy care resident must be re-authorized by the resident's ACH/CMS case manager at least annually.

To receive Enhanced ACH/PC payments for more than 12 months since the effective date in the last Decision Notice, you must provide the case manager with a copy of the resident's current assessment and care plan and any other available records to document the resident's abilities, limitations, and need for assistance. The case manager must verify the resident's continuing eligibility for coverage, notify EDS, and send the resident and you a Decision Notice.